

MONTHLY IMMUNIZATION REPORT - Revised June 2005

Practice/Facility Name:	E-Mail Address:	County:	VFC PIN Number:
Street Address:	City:	Zip Code:	Phone Number ()
Contact Person:	Reporting Month:	Reporting Year:	Fax Number ()

Vaccine Inventory by Number of Doses								Number of Clients by Category				
VACCINE TYPE	Beginning Monthly Vaccine Inventory	Vaccine Received In From State	Total Amount of Vaccine Administered	Vaccine Transferred to/from Another VFC Provider--include PIN #	Expired or Wasted Vaccine	Unaccounted For Vaccine Doses Long or Short (+ or -)	Ending Monthly Vaccine Inventory	Eligibility Status	Age of Clients			
									<1 Yr	1-2 Yr	3-6 Yr	7-18 Yr
DT								Medicaid (VFC)				
Td								Uninsured (VFC)				
DTaP								Native American (VFC)				
DTaP/HepB/EIPV								Under-Insured* (VFC)				
Hib								HealthWave (VFC)				
Polio								Under-Insured* (CHD Only)				
Hepatitis A								Under-Served (CHD Only)				
Hepatitis B (Adult)								*Only include if facility is a FQHC or RHC. Under-Insured: Health insurance plan does not include coverage for vaccination, covers only select vaccines, or caps the vaccine cost at a limit below the actual cost of the vaccine. Under-Served: Health insurance plan has co-pay or deductible that is high enough to provide a barrier to immunizations. This report is due each month by the 10 th day of the month following the reporting period.				
Hepatitis B (Ped)												
Hepatitis B-Hib												
MMR												
Pneumococcal-Conj												
Meningococcal												
Influenza												
Varicella												
TOTAL												

E-MAIL: wevens@kdhe.state.ks.us

FAX: 785-296-6510 (Call 785-296-5591 to assure fax has been received)

MAIL: Kansas Immunization Program, 1000 SW Jackson Street, Suite 210, Topeka, KS 66612-1274

FORMS AVAILABLE AT: www.kdhe.state.ks.us/immunize